BHSF Form MNP/SG
Rev. 03/03
Prior Issues Obsolete
II

Medicaid Program
Spend-Down Quarter Screening Guide

Complete this form as an original only and file in the case record.

Complete this form, as follows, in order to explore and document the quarter of coverage needed for Medically Needy Spend-Down.

1. Circle the month of application.
2. Highlight the three months preceding the month of application, the month of application and the two months following the application month.
3. Put an "X" in each block of the highlighted months in which a medical bill has been incurred.
4. Explain the advantages of the proposed quarters of coverage based on the applicant's needs. Obtain the applicant's decision regarding the quarter of coverage requested.
5. Record the applicant's decision regarding quarter of coverage being requested. Both the applicant and the agency representative must sign and date the document.

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
____	____	____	____	____	____	____	____	____	____	____	____

Quarter of coverage requested: _____ (Month), _____ (Month), _____ (Month)

_____ Signature of Applicant

_____ Date

_____ Signature of Agency Representative

_____ Date

6. If the applicant requests a different quarter of coverage than that documented above prior to the Spend-Down certification complete the quarter of coverage change block below:

I am requesting that my quarter of coverage be changed from the above to the following months: _____, _____, and _____.

_____ Signature of Applicant

_____ Date

_____ Signature of Agency Representative

_____ Date